PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council, Tuesday, August 20, 2002, 10:00 a.m., Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Dr. Howard Koh (Chairman), Ms. Phyllis Cudmore, Dr. Thomas Sterne, Dr. Martin Williams, and Ms. Maureen Pompeo. Absent members were: Mr. Manthala George, Jr., Ms. Shane Kearney Masaschi, Mr. Benjamin S. Rubin, and Ms. Janet Slemenda. Also in attendance was Attorney Donna Levin, General Counsel.

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Chairman Koh announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, Chapter 30A, Section 11A ½.

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The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Ms. Carolyn Castro-Donlan, Deputy Director, and Ms. Alexandria Kearns, Licensing Specialist, Bureau of Subtance Abuse Services; Ms. Joyce James, Director, Determination of Need Program; and Attorney Edward Sullivan, Deputy General Counsel, Office of the General Counsel.

RECORDS OF THE PUBLIC HEALTH COUNCIL:

Records of the Public Health Council Meeting of May 28, 2002 were presented to the Council. After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve Records of the Public Health Council Meeting of May 28, 2002.

PERSONNEL ACTIONS:

In a letter dated August 7, 2002, Katherine Domoto, M.D., Associate Executive Director for Medicine, Tewksbury Hospital, Tewksbury, recommended approval of the reappointments to the medical staff of Tewksbury Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Associate Executive Director for Medicine of Tewksbury Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following reappointments to the various medical staffs of Tewksbury Hospital be approved for a period of two years beginning August 1, 2002 to August 1, 2004:

REAPPOINTMENTS	STATUS/SPECIALTY	MEDICAL LICENSE NO.

David Morin, M.D.	Active/Internal Medicine/Psychiatry	54798
Herminia D. Rosas, M.D.	Consultant/Neurology	151574

In a letter dated August 12, 2002, Paul D. Romary, Executive Director, Lemuel Shattuck Hospital, Jamaica Plain, recommended approval of initial appointments and reappointments to the medical and allied health staffs of Lemuel Shattuck Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the initial appointments and reappointments to the medical and allied health staffs of Lemuel Shattuck Hospital be approved as follows:

APPOINTMENTS	**STATUS/SPECIALTY**	**MEDICAL LICENSE NO.**
Mario Addabo, M.D.	Active/Anesthesiology	209873
David Gorman, M.D.	Consultant/Psychiatry	210416
Alexandrina Darabus, M.D.	Consultant/Psychiatry	212468
Paul Weigle, M.D.	Consultant/Psychiatry	209361

REAPPOINTMENTS	**STATUS/SPECIALTY**	**MEDICAL LICENSE NO.**
Shahla Asvadi, M.D.	Consultant/Dermatology	52195
Leendert J. Faling, M.D.	Consultant/Pulmonary Medicine	28703
Punyamurtula Kishore, M.D.	Consultant/Internal Medicine	43282
Robert Tarpy, M.D.	Consultant/Pulmonary Medicine	72824
Rachelle Hotz, M.D.	Active/Psychiatry	53458
John Hsu, D.M.D.	Consultant/Dentistry	15958
Andre St. Germain, D.M.D.	Consultant/Dentistry	10608
Farhat Homsy, M.D.	Consultant/General Surgery	45108
Ellena Diggins, P.A.	Allied Health Professional	333

Lemuel Shattuck Hospital also indicated the following resignations: Christopher Gill, M.D., Consultant for Internal Medicine, Philip McAndrew, M.D., Consultant for Internal Medicine, Justina Tseng, M.D., Consultant for Internal Medicine, and George Younis, M.D., Consultant for Internal Medicine.

REGULATIONS:

REQUEST FOR PROMULGATION OF FINAL AMENDMENTS TO 105 CMR 168.000: STANDARDS FOR THE LICENSURE OF ALCOHOL AND DRUG COUNSELORS:

Ms. Carolyn Castro-Donlan, Deputy Director, Bureau of Substance Abuse Services, presented the final amendments to 105 CMR 168.000 to the Council, accompanied by Ms. Alexandria Kearns, Licensing Specialist and Attorney Edward Sullivan, Deputy General Counsel.

Ms. Castro-Donlan said, "…The Department of Public Health, through the Bureau of Substance Abuse Services, is authorized by M.G.L.c.111J to promulgate regulations to license alcohol and drug counselors in the Commonwealth of Massachusetts….After producing a draft in cooperation with the 111J Advisory Committee, and receiving internal approval, the Bureau held a public hearing in September of 2001. Following the September 2001 hearing, an amendment to the M.G.L.c.111J was filed with the Legislature that added grandparenting provisions to the original statute. The Governor signed the amendment into law in March as Chapter 60 of the Acts of 2002. The Bureau updated the proposed regulations to include appropriate grandparenting provisions. The final draft has been approved by the Department staff and the Advisory Group. It includes the following major sections: Definitions, Exemptions, Eligibility Requirements, Application Process, Examinations, Term of Licensure, Grandparenting, Reciprocity, Continuing Education, and Administrative and Legal Procedures. The final hearing on these regulations was held July 16th of 2002. The Bureau received no public comment hearing…We believe the proposed regulations will provide alcohol and drug counselors the opportunity to obtain a license based on their specialized experience and expertise that will improve the quality of these services throughout the Commonwealth."

After consideration, upon motion made and duly seconded, it was voted (unanimously): That, The Request **for Promulgation of Final Amendments to 105 CMR 168.000: Standards for the Licensure of Alcohol and Drug Counselors** be approved; that a copy be forwarded to the Secretary of the Commonwealth; and that a copy be attached and made a part of this record as **Exhibit No. 14,736.**

REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO HOSPITAL LICENSURE REGULATIONS 105 CMR 130.000 ET SEQ. REGARDING THE PROVISION OF TRAUMA SERVICES:

Dr. Paul Dreyer, Director, Division of Health Care Quality, presented amendments to the hospital licensure regulations 105 CMR 130.000 to the Council. He noted, "…I believe this is the third time we have been before you on these regulations. These regulations are necessitated by provisions of the EMS 2000 Statute, which prohibits any hospital from holding itself out as a trauma center unless it has been so designated by the Department, and the deadline for that requirement was March 26, 2002. We promulgated a definition of trauma center on an emergency basis, whose purpose was to recognize the status quo until the State Trauma Committee could come forth with a more complete specification of what a trauma center should be. These regulations went to public hearing. There were no comments. We are asking for final promulgation of these regulations, which are final in this phase, but we will be coming back at a later date, once we have a more substantive definition of a trauma center, and we will bring those before the Council at that time. We are asking promulgation of these regulations which will

enable hospitals to continue to call themselves trauma centers, as they have been, until we come forward with the trauma center committee recommendations." Staff's memorandum indicated that the final regulation, unchanged from the emergency promulgation – allows a hospital to continue to use the terms "trauma facility," "trauma center" or similar terminology in its signs or advertisements if it meets one of two tests:

(1) it has verification from the American College of Surgeons (ACS) as a Level I, II, or III trauma center; or,

(2) it has been recognized in a regional point of entry plan as a recipient of trauma patients.

After consideration, upon motion made and duly seconded, it was voted (unanimously): That the **Request for Final Promulgation of Amendments to Hospital Licensure Regulations 105 CMR 130.000 et seq. Regarding the Provision of Trauma Services** be approved; that a copy be forwarded to the Secretary of the Commonwealth; and that a copy be attached and made a part of this record as **Exhibit No**.**14,737**.

DETERMINATION OF NEED PROGRAM:

COMPLIANCE MEMORANDUM: PREVIOUSLY APPROVED DON PROJECT NO. 2-3A02 OF MILFORD-WHITINSVILLE REGIONAL HOSPITAL, INC.:

Ms. Joyce James, Director, Determination of Need Program, presented the request by Milford-Whitinsville Regional Hospital, Inc. to increase its maximum capital expenditure and the gross square footage of the project and the equity contribution of the recently appoved DoN to add medical surgical beds and modernize the hospital's physical plant.

Ms. James said, "…The hospital has explained that the proposed changes here were unforeseen at the time the application was filed. It was during the post planning and development phase of the process when the hospital was preparing preliminary plans for submission to the Division of Health Care Quality for approval that serious spatial deficiencies were identified in the initial project design, which would have made it very difficult for the hospital to operate efficiently. The proposed increase in the gross square footage is for extensive renovation of the existing facility to correct these deficiencies, and the increase in the equity contribution is to offset some of the renovation costs."

Mr. Francis M. Saba, President, Milford-Whitinsville Hospital, "I just want to thank you for hearing our request so promptly. Basically, we feel that the changes we are proposing in this amendment will make the project a better project and will increase the efficiency, especially the operational efficiency of the services that we are dealing with in this project. Basically, we decided, after looking at the original plan, that one thing we needed to do was relocate the kitchen from where we had originally thought we would put it, to create some efficiencies in regards to the kitchen and cafeteria flow, the work flow. The other thing we needed to do was create some support space for our surgery department. We were adding new ORs in the original proposal and to support those ORs, we needed to create some additional support space for the

anesthesia staff and for the OR staff, and so forth. Those are the two main components of the changes that we are proposing in this amendment."

In response to Council Member Sterne's question of why these changes weren't anticipated at the time of the original project, Mr. Robert Humenn, architect of Steffian and Bradley Associates & Architects, said, "The reason that they weren't anticipated is that the existing kitchen is located in a building that will be demolished to make way for the new addition that houses the new surgical suite and medical/surgical nursing unit. We were locating the kitchen in new construction at the back part of the site to get it out of the way of the first phase. That was separated from the cafeteria by one floor. We thought that we could make that work. We could obviously make it work physically. In the interim, between when the DoN was approved and we were doing our schematic design, we brought in a kitchen consultant, and he determined that we would add three empty eaves, and add quite a bit of food service equipment in order to be able to transport food from the kitchen to the cafeteria. We did not expect that magnitude of a change."

Staff's memorandum to the Council indicated the following:

"The inflation-adjusted increase of $3,868,196 (July 2002 dollars) requested by the holder is the net effect of a $4,967,673 increase in renovation costs and a $1,099,477 decrease in new construction costs. A breakdown of the $4,967,673 renovation costs include an increase of $3,452,158 in construction contract, $1,056,100 in fixed equipment not in contract, $311,301 in architectural and engineering costs, and $148,114 in major movable equipment. Supporting documentation and a subsequent meeting with the holder's representatives indicate that the new construction and renovation planned under the originally approved project would result in spatial deficiencies, impractical adjacencies, operational inefficiencies, and patients' inconvenience. For example, the kitchen was separated from the cafeteria, and pre-admission testing area was not adjacent to the surgical suite. Additionally, the small size laboratory space could not accommodate the increasing demand for services, and location of the volunteer department was not readily accessible to assist patients and their families. The holder in consultation with its architect and other consultants determined that a reconfiguration of the space for these services and facilities would correct the design problems. Accordingly, the gross square footage (GSF) for renovation was increased from 3,500 to 15,860 and the GSF for new construction decreased from 54,500 to 50,200.

The proposed increase in the GSF for renovation allows conversion of existing space to a new kitchen, which accounts for approximately 5,000 of the 12,360 GSF increase. This increase also allows conversion of existing space to operating room office space, other office and storage space, central sterile supply storage and addition of private bedrooms, as well as relocation of the pre-admission testing area, respiratory care unit, volunteer department and a morgue. The decrease in new construction still allows construction of a three (3) story addition and one (1) story vertical expansion to accommodate the existing and new medical/surgical beds, and relocation and expansion of other services and facilities as originally approved. In addition to these activities, the new construction also allows addition of a post-anesthesia care unit and surgical day care, and expansion of the surgical center. As amended, the new one story vertical new construction will also include a relocated and expanded laboratory, swing space for temporary moves during construction and space for mechanical infrastructure. The holder notes

that the proposed renovation would enable the Hospital to improve patient flow, increase patient convenience and enhance operational efficiency.

The supporting documentation and discussions with the holder's representatives indicate that two major factors contribute to the increase in the construction contract for renovation. One is the increase in the GSF for renovation, discussed above, and the other is the cost/GSF for renovation, which exceeds the Department's allowable cost/GSF. The costs of converting the existing cafeteria and a morgue into a new kitchen are significantly high, because of the extensive plumbing work for cooking and dishwashing area, including grease traps that must be cut into an existing concrete floor. Renovations also include electrical wiring and circuitry, extensive mechanical cooling and ventilation systems, and compliance with emergency power requirements prescribed by law for food service. Other complex renovations include installing mechanical, electrical and fire protection services in other areas, trenching plumbing lines through a concrete floor slab, raising an existing floor, and installing staff toilets and showers. Adding to the renovation costs is the construction of a temporary enclosure to separate the operational portions of the hospital from the renovations, to minimize disruption to the hospital's operation and ensure safety of the hospital's patients. Also to minimize system shutdowns, the renovation work must occur after normal workday hours and during weekends, which, during these premium time hours, increases the labor costs. Due to the change in the nature and scope of the renovations, the construction period has been increased from 12 months, as originally planned, to 21 months. There is also asbestos abatement, which is required on a much larger scale than anticipated in the original project approval. In general, the age and condition of the building, which was constructed in 1930, make the complexities of the renovation more costly and comparable to new construction costs.

The increase in the fixed equipment not in contract was the portion of the cost that was originally included under new construction but was reassigned to the renovation cost to reflect the installation of new kitchen equipment. The architectural and engineering costs for renovation were also reassigned from the new construction costs, due to the post-planning and development work undertaken to expand the renovated areas. The major movable equipment cost relates to the equipment necessary for the relocation of the laboratory and administrative offices.

In response to staff's request, the holder has submitted documentation explaining why these proposed changes to the project were not anticipated during the pre-planning and development phase prior to filing the determination of need application. The holder asserts that the hospital and its architect based it on the best information available at the time and believed that the approved project design was the best available to accomplish the hospital's goals. During the post-planning and development phase of the project, the holder and its architect engaged mechanical electrical engineer, food service operations and patient care operations consultants in the preparation of preliminary plans for submission to the Department's Division of Health Care Quality for approval. The holder notes that this is a typical sequence of events among hospitals engaged in the determination of need process, because hospitals generally have limited resources to dedicate to operational consultants and architectural and engineering costs prior to project approval.

The holder indicates that the consultations enabled the hospital to identify certain inefficiencies associated with the spatial arrangement of the services to be located in the newly constructed and renovated space as originally approved. For example, the original spatial design of separating the kitchen from the cafeteria, discussed earlier, would create operational difficulties, increasing staffing requirements by approximately two full-time equivalents and increase equipment costs due to duplicate dishwashers, refrigerators and food warmers. The spatial arrangement of the pre-testing admission area would create patient confusion and increase patient inconvenience. The laboratory space would be inefficient to operate and would not accommodate the increasing service demand. Staff agrees with the holder's assessment since the determination of need application asks only for schematic line drawings of the project's proposed new construction and renovation. The submission of more detailed architectural plans and specifications is part of the licensure approval process, which occurs after the project has received determination of need approval."

After consideration, upon motion made and duly seconded, it was voted unanimously to approve the request by **Previously Approved DoN Project No. 2-3A02 of Milford-Whitinsville Regional Hospital, Inc., with conditions** to increase the maximum capital expenditure and the gross square footage of the project as follows:

	New Construction	Renovation
Land Costs:		
Site Survey & Soil Investigation	$ 25,000	$ -
Total Land Costs	25,000	-
Construction Costs:		
Depreciable Land Development Costs	50,000	-
Construction Contract (includes bonding contract)	16,433,104	3,991,776
Fixed Equipment not in Contract	4,224,400	1,056,100
Architectural & Engineering Costs	1,454,260	373,565
Pre-Filing Planning & Development	30,000	-
Post-Filing Planning & Development	10,000	-
Net Interest Expense During Construction	2,991,795	-
Major Movable Equipment	800,000	200,000
Total Construction Costs	25,993,559	5,621,441
Financing Costs:		
Costs of Securing Financing	560,000	-
Other: Debt Service Reserve Fund	2,800,000	-
Total Financing Costs	3,360,000	-
Subtotal	$ 29,378,559	$5,621,441

Total Maximum Capital Expenditure $35,000,000

This Amendment is subject to the following conditions:

1. The approved GSF for this project shall be 66,060, including 50,200 GSF for new construction and 15,860 GSF for renovation.

2. The holder shall contribute 20.0% equity ($7,000,000 July 2002 dollars) toward the final approved MCE.

3. All other conditions attached to the original and amended approval of this project shall remain in effect.

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The meeting adjourned at 11:10 a.m.

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Howard K. Koh, M.D., M.P.H.
Chairman

LMH/lmh